

**Physician's Request for  
Administration of Medicine  
By City of Brea Personnel**

Name of Participant:	Date of Birth:
Address:	
City/Zip Code:	Phone No.:
<b>EMERGENCY PHONE NUMBER:</b>	
Physical condition for which drug is to be given. (If allergic in nature, please specify what type of reaction, i.e., localized, generalized, mild, severe)	
Medication:	
Dosage and method of administration:	
Possible reactions that need to be reported to the physician:	
Disposition of participant following administration of medication, i.e., rest, home, hospital, doctor's office, return to program:	

The above medication cannot be scheduled for other than during Program hours and such medication may be administered by medically untrained personnel whenever necessary.
Medication to be continued as above until (date):
Physician's Address:
Physician's Phone Number:
Physician's Name (stamped)
Date of Request:

The City of Brea staff has been given directions for dispensing medicine to the above listed child and has my permission to do so.
Parent/Guardian Signature:
Date:
Staff Signature: <span style="float: right;">Supervisor Initial:</span>